

FORM **HHCS-3**
(3-21-2000)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS COLLECTING AGENT FOR THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

**CURRENT PATIENT
QUESTIONNAIRE**
**2000 NATIONAL HOME AND
HOSPICE CARE SURVEY**

NOTICE - Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; Paperwork Reduction Project (0920-0298) 1600 Clifton Road, MSD-24, Atlanta, GA 30333. Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

Section A - ADMINISTRATIVE INFORMATION

1. Field representative name	2. FR code	3. Date of interview		
		Month	Day	Year

Section B - PATIENT INFORMATION

Current patient line number →

Section C - STATUS OF INTERVIEW

- 01 Complete
- 02 Partial
- 03 Patient included in sampling list in error - **Explain in NOTES section.**
- 04 Incorrect sample line number selected
- 05 Refused
- 06 Assessment only
- 07 Unable to locate record - **Explain in NOTES section.**
- 08 Less than 6 patients selected
- 09 Other noninterview - **Explain in NOTES section.**
- 10 No current patients

NOTES

- 01 Mark (X) this box if comments are written in this section or any other place on this questionnaire.

Read to each new respondent.

In order to obtain national level data about the patients of hospices and home health agencies such as this one, we are collecting information about a sample of current patients. I will be asking questions about the background, health status, treatment, social contacts, and billing information for each sampled patient.

The information you provide will be held in strict confidence and will be used ONLY by persons involved in the survey and only for the purposes of the survey.

In answering these questions, it is especially important to locate the information in the patient's medical record. Do you have the medical file(s) and record(s) for the selected current patient(s)?

If not, ask the respondent to get it/them prior to beginning the interview. Fill sections A and B on the front of all the current patient forms while the respondent gets the records. If no record is available for a patient, try to obtain as much information as possible from whatever administrative records are available and/or from the respondent's memory.

1. What is this patient's sex?

- 01 Male
02 Female

2. What is her/his date of birth?

Current age

Month	Day	Year

OR _____ OR _____
Years Months

3a. Is she/he of Hispanic or Latino origin?

- 01 Yes
02 No
03 Don't know

HAND FLASHCARD 1.

b. Which of these best describes her/his race?

Mark (X) all that apply.

PROBE: Any others?

- 01 American Indian or Alaska Native
02 Asian
03 Black or African American
04 Native Hawaiian or other Pacific Islander
05 White
06 Other - Specify

NOTE - Hispanic is NOT a race.

- 07 Don't know

4. What is her/his current marital status?

Mark (X) only one box.

- 01 Married
02 Widowed
03 Divorced
04 Separated
05 Never married
06 Single
07 Don't know

HAND FLASHCARD 2.

5a. Where is she/he currently living?

Mark (X) only one box.

- 01 Private residence (house or apartment)
02 Rented room, boarding house
03 Retirement home or apartment, including elderly housing
04 Board and care, assisted living, or residential care facility
05 Nursing home, hospital, or other inpatient health facility (including mental health facility) - SKIP to item 6 Introduction
06 Other - Specify

b. Is she/he living with family members, nonfamily members, both family and nonfamily members, or alone?

- 01 With family members
02 With nonfamily members
03 With both family members and nonfamily members
04 Alone
05 Don't know

HAND FLASHCARD 3.

6. Who referred her/him to this agency?

Mark (X) all that apply.

PROBE: Any other sources?

- 01 Self/Family
- 02 Nursing home
- 03 Hospital
- 04 Physician
- 05 Health department
- 06 Social service agency
- 07 Home health agency
- 08 Hospice
- 09 Religious organization
- 10 Health maintenance organization
- 11 Friend/Neighbor
- 12 Other - Specify

13 Don't know

7. What was the date of her/his most recent admission with your agency, that is, the date on which she/he was admitted for the current episode of care?

Month		Day		Year	

03 Only an assessment was done for this patient (patient was not provided services by this agency)

8a. According to the medical record, what were the primary and other diagnoses at the time of that (admission/assessment)?

PROBE: Any other diagnoses?

- 01 No diagnosis
- 02 Admission diagnoses unknown

Primary: 1 _____

Others: 2 _____

3 _____

4 _____

5 _____

6 _____

Refer to Q7. If **ONLY** an assessment was done for this patient, END THE INTERVIEW AND MARK STATUS CODE "06" IN SECTION C ON THE COVER. THEN GO TO the next current patient questionnaire.

If the patient was admitted to the agency and provided services by the agency, CONTINUE this interview.

b. According to the medical records, what are her/his CURRENT primary and other diagnoses?

PROBE: Any other diagnoses?

- 01 No diagnosis
- 02 Same as 8a
- 03 Current diagnoses unknown

Primary: 1 _____

Others: 2 _____

3 _____

4 _____

5 _____

6 _____

c. According to the medical record, did she/he have any diagnostic or surgical procedures that were related to her/his admission to this agency?

- 01 Yes
- 1 _____
- 2 _____
- 02 No procedures

<p>9. What type of care is she/he currently receiving from your agency? Is it home health care, home care, or hospice care?</p>	<p>01 <input type="checkbox"/> Home health care or home care 02 <input type="checkbox"/> Hospice care 02a <input type="checkbox"/> In the home or usual place of residence 02b <input type="checkbox"/> Inpatient</p>
<p>10a. Does she/he have a primary caregiver outside of this agency?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No } <i>SKIP to item 11</i> 03 <input type="checkbox"/> Don't know</p>
<p>b. Does she/he usually live with (her/his) primary caregiver?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know</p>
<p><i>HAND FLASHCARD 5.</i></p> <p>c. What is the relationship of the primary caregiver to the patient?</p> <p><i>Mark (X) only one box.</i></p>	<p>01 <input type="checkbox"/> Spouse 02 <input type="checkbox"/> Parent 03 <input type="checkbox"/> Child, including daughter- or son-in-law 04 <input type="checkbox"/> Sister or brother, including sister- or brother-in-law 05 <input type="checkbox"/> Other relative - <i>Specify</i> <u> </u></p> <hr/> <p>06 <input type="checkbox"/> Friend or neighbor 07 <input type="checkbox"/> Paid help or staff of facility where patient resides 08 <input type="checkbox"/> Other - <i>Specify</i> <u> </u></p> <hr/> <p>09 <input type="checkbox"/> Don't know</p>
<p><i>HAND FLASHCARD 6.</i></p> <p>11. During the last 30 days/Since admission, which of these aids or special devices did she/he regularly use?</p> <p><i>Mark (X) all that apply.</i></p> <p>PROBE: Any other aids?</p>	<p>00 <input type="checkbox"/> No aids used 01 <input type="checkbox"/> Bedside commode 02 <input type="checkbox"/> Blood glucose monitor 03 <input type="checkbox"/> Cane, crutches 04 <input type="checkbox"/> Dentures (full or partial) 05 <input type="checkbox"/> Elevated/raised toilet seat 06 <input type="checkbox"/> Enteral feeding equipment 07 <input type="checkbox"/> Eyeglasses (including contact lenses) 08 <input type="checkbox"/> Geri-chairs, lift chairs, other specialized chairs 09 <input type="checkbox"/> Grab bars 10 <input type="checkbox"/> Hearing aid 11 <input type="checkbox"/> Hospital bed 12 <input type="checkbox"/> IV therapy equipment 13 <input type="checkbox"/> Mattress, special (eggcrate, foam, air, gel, etc.) 14 <input type="checkbox"/> Orthotics, including braces 15 <input type="checkbox"/> Overbed table</p> <p>Respiratory therapy equipment</p> <p>16 <input type="checkbox"/> Oxygen (including oxygen concentrator) 17 <input type="checkbox"/> Other respiratory therapy equipment</p> <p>18 <input type="checkbox"/> Shower chair/Bath bench 19 <input type="checkbox"/> Transfer equipment 20 <input type="checkbox"/> Walker 21 <input type="checkbox"/> Wheel chair - Manually operated 22 <input type="checkbox"/> Wheel chair - Motorized (including scooter) 23 <input type="checkbox"/> Other - <i>Specify</i> <u> </u></p>

<p>For items 12a-13b, refer to item 11.</p>	
<p>12a. Does she/he have any difficulty in seeing (when wearing glasses)?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Not applicable (e.g., comatose) .. 04 <input type="checkbox"/> Don't know</p> <p>} <i>SKIP to item 13a</i></p>
<p><i>HAND FLASHCARD 7.</i></p>	
<p>b. Is her/his sight (when wearing glasses) partially, severely, or completely impaired as defined on this card?</p>	<p>01 <input type="checkbox"/> Partially impaired 02 <input type="checkbox"/> Severely impaired 03 <input type="checkbox"/> Completely lost, blind 04 <input type="checkbox"/> Don't know</p>
<p>13a. Does she/he have any difficulty in hearing (when wearing a hearing aid)?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Not applicable (e.g., comatose) .. 04 <input type="checkbox"/> Don't know</p> <p>} <i>SKIP to item 14a</i></p>
<p><i>HAND FLASHCARD 8.</i></p>	
<p>b. Is her/his hearing (when wearing a hearing aid) partially, severely, or completely impaired, as defined on this card?</p>	<p>01 <input type="checkbox"/> Partially impaired 02 <input type="checkbox"/> Severely impaired 03 <input type="checkbox"/> Completely lost, deaf 04 <input type="checkbox"/> Don't know</p>
<p>14a. Does she/he have an indwelling urinary catheter or urostomy?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know</p> <p>} <i>SKIP to item 15</i></p>
<p>b. Does she/he receive assistance from your agency staff in caring for this device?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know</p> <p>} <i>SKIP to item 16a</i></p>
<p>15. Does she/he currently have any difficulty in controlling (his/her) bladder?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Infant 04 <input type="checkbox"/> Don't know</p>
<p>16a. Does she/he have a colostomy or ileostomy?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know</p> <p>} <i>SKIP to item 17</i></p>
<p>b. Does she/he receive assistance from your agency staff in caring for this device?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know</p> <p>} <i>SKIP to item 18</i></p>
<p>17. Does she/he currently have any difficulty in controlling (his/her) bowels?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Infant 04 <input type="checkbox"/> Don't know</p>

NOTES

HAND FLASHCARD 9.		Yes	No	Don't know	Not applicable (e.g., patient is bedfast)
18.	During the last 30 days/Since admission, did she/he receive personal help from this agency in any of the following activities as defined on this card - - <i>Mark (X) one box for each activity.</i>				
a.	Bathing or showering?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
b.	Dressing?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
c.	Eating?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
d.	Transferring in or out of beds or chairs?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
e.	Walking?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
f.	Using the toilet room?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
HAND FLASHCARD 10.		Yes	No	Don't know	Not applicable (e.g., patient is bedfast)
19.	During the last 30 days/Since admission, did she/he receive personal help from your agency in any of the following activities as defined on this card - <i>Mark (X) one box for each activity.</i>				
a.	Doing light housework?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
b.	Managing money?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
c.	Shopping for groceries or clothes?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
d.	Using the telephone (dialing or receiving calls)?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
e.	Preparing meals?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
f.	Taking medications?	01 <input type="checkbox"/>	02 <input type="checkbox"/>	03 <input type="checkbox"/>	04 <input type="checkbox"/>
HAND FLASHCARD 11.					
20a.	Which of these services did she/he receive FROM YOUR AGENCY during the last 30 days/since admission? <i>Mark (X) all that apply.</i>				
	PROBE: Any other services?				
00	<input type="checkbox"/> None	16	<input type="checkbox"/> Physician services		
01	<input type="checkbox"/> Companion services	17	<input type="checkbox"/> Psychological services		
02	<input type="checkbox"/> Continuous home care	18	<input type="checkbox"/> Referral services		
03	<input type="checkbox"/> Counseling	19	<input type="checkbox"/> Respiratory therapy		
04	<input type="checkbox"/> Dental treatment services	20	<input type="checkbox"/> Respite care		
05	<input type="checkbox"/> Dietary/nutritional services	21	<input type="checkbox"/> Skilled nursing services		
06	<input type="checkbox"/> Durable medical equipment and supplies	22	<input type="checkbox"/> Social services		
07	<input type="checkbox"/> Enterostomal therapy	23	<input type="checkbox"/> Speech therapy/Audiology		
08	<input type="checkbox"/> Homememaker-household services	24	<input type="checkbox"/> Spiritual care		
09	<input type="checkbox"/> IV therapy	25	<input type="checkbox"/> Transportation		
10	<input type="checkbox"/> Meals on Wheels	26	<input type="checkbox"/> Vocational therapy		
11	<input type="checkbox"/> Medications	27	<input type="checkbox"/> Volunteer services		
12	<input type="checkbox"/> Occupational therapy	28	<input type="checkbox"/> Other high tech care (e.g., enteral nutrition, dialysis)		
13	<input type="checkbox"/> Pastoral care	29	<input type="checkbox"/> Other services - <i>Specify</i> <u> </u>		
14	<input type="checkbox"/> Personal care				
15	<input type="checkbox"/> Physical therapy				

HAND FLASHCARD 12.

20b. Which of these service providers FROM YOUR AGENCY visited her/him during the last 30 days/since admission?

Mark (X) all that apply.

PROBE: Any other providers?

- 00 None
- 01 Chaplain
- 02 Dietitians/Nutritionists
- 03 Home health aides
- 04 Homemakers/Personal caretakers
- 05 Licensed practical or vocational nurses
- 06 Mental health specialists
- 07 Nursing aides and attendants
- 08 Occupational therapists
- 09 Physical therapists
- 10 Physicians
- 11 Registered nurses
- 12 Respiratory therapists
- 13 Social workers
- 14 Speech pathologists/Audiologists
- 15 Volunteers
- 16 Other providers - Specify

HAND FLASHCARD 13.

21. What is the PRIMARY expected source of payment for her/his care?

Mark (X) only one source.

For the source of payment ask: Is the (source of payment) for home health care or hospice care?

- | | Home Health
Care | Hospice
Care |
|--|------------------------------|------------------------------|
| 01 <input type="checkbox"/> Medicare | 01 <input type="checkbox"/> | 01 <input type="checkbox"/> |
| a. Fee-for-service Medicare | 01a <input type="checkbox"/> | 01a <input type="checkbox"/> |
| b. Medicare HMO | 01b <input type="checkbox"/> | 01b <input type="checkbox"/> |
| 02 <input type="checkbox"/> Medicaid | 02 <input type="checkbox"/> | 02 <input type="checkbox"/> |
| a. Fee-for-service or traditional Medicaid | 02a <input type="checkbox"/> | 02a <input type="checkbox"/> |
| b. Privately insured through Medicaid .. | 02b <input type="checkbox"/> | 02b <input type="checkbox"/> |
| 03 <input type="checkbox"/> Other government medical assistance .. | 03 <input type="checkbox"/> | 03 <input type="checkbox"/> |
| 04 <input type="checkbox"/> Private insurance | 04 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| a. HMO or IPA | 04a <input type="checkbox"/> | 04a <input type="checkbox"/> |
| b. Indemnity plan or PPO | 04b <input type="checkbox"/> | 04b <input type="checkbox"/> |
| c. Other - Specify <u> </u> | | |
| _____ | 04c <input type="checkbox"/> | 04c <input type="checkbox"/> |
| 05 <input type="checkbox"/> Own income, family support, Social Security benefits, retirement funds, or welfare | 05 <input type="checkbox"/> | 05 <input type="checkbox"/> |
| 06 <input type="checkbox"/> Supplemental Security Income (SSI) | 06 <input type="checkbox"/> | 06 <input type="checkbox"/> |
| 07 <input type="checkbox"/> Religious organizations, foundations, agencies | 07 <input type="checkbox"/> | 07 <input type="checkbox"/> |
| 08 <input type="checkbox"/> Veterans Administration | 08 <input type="checkbox"/> | 08 <input type="checkbox"/> |
| 09 <input type="checkbox"/> CHAMPVA/CHAMPUS | 09 <input type="checkbox"/> | 09 <input type="checkbox"/> |
| 10 <input type="checkbox"/> Other military medicine | 10 <input type="checkbox"/> | 10 <input type="checkbox"/> |
| 11 <input type="checkbox"/> Other - Specify <u> </u> | | |
| _____ | 11 <input type="checkbox"/> | 11 <input type="checkbox"/> |
| 12 <input type="checkbox"/> Payment source not yet determined ... | SKIP to item 24 | |
| 13 <input type="checkbox"/> No charge made for care | SKIP to item 25 | |

22. What are ALL the secondary sources of payment for her/his care?

Mark (X) all that apply.

PROBE: Any other sources of payment?

For the source of payment ask:
is the (source of payment) for home health care or hospice care?

	Home Health Care	Hospice Care
00 <input type="checkbox"/> No secondary sources		
01 <input type="checkbox"/> Medicare	01 <input type="checkbox"/>	01 <input type="checkbox"/>
a. Fee-for-service Medicare	01a <input type="checkbox"/>	01a <input type="checkbox"/>
b. Medicare HMO	01b <input type="checkbox"/>	01b <input type="checkbox"/>
02 <input type="checkbox"/> Medicaid	02 <input type="checkbox"/>	02 <input type="checkbox"/>
a. Fee-for-service or traditional Medicaid	02a <input type="checkbox"/>	02a <input type="checkbox"/>
b. Privately insured through Medicaid	02b <input type="checkbox"/>	02b <input type="checkbox"/>
03 <input type="checkbox"/> Other government medical assistance	03 <input type="checkbox"/>	03 <input type="checkbox"/>
04 <input type="checkbox"/> Private insurance	04 <input type="checkbox"/>	04 <input type="checkbox"/>
a. HMO or IPA	04a <input type="checkbox"/>	04a <input type="checkbox"/>
b. Indemnity plan or PPO	04b <input type="checkbox"/>	04b <input type="checkbox"/>
c. Other - Specify <u> </u>		
_____	04c <input type="checkbox"/>	04c <input type="checkbox"/>
05 <input type="checkbox"/> Own income, family support, Social Security benefits, retirement funds, or welfare	05 <input type="checkbox"/>	05 <input type="checkbox"/>
06 <input type="checkbox"/> Supplemental Security Income (SSI)	06 <input type="checkbox"/>	06 <input type="checkbox"/>
07 <input type="checkbox"/> Religious organizations, foundations, agencies	07 <input type="checkbox"/>	07 <input type="checkbox"/>
08 <input type="checkbox"/> Veterans Administration	08 <input type="checkbox"/>	08 <input type="checkbox"/>
09 <input type="checkbox"/> CHAMPVA/CHAMPUS	09 <input type="checkbox"/>	09 <input type="checkbox"/>
10 <input type="checkbox"/> Other military medicine	10 <input type="checkbox"/>	10 <input type="checkbox"/>
11 <input type="checkbox"/> Other - Specify <u> </u>		
_____	11 <input type="checkbox"/>	11 <input type="checkbox"/>

23a. What was the last amount billed for her/his care, including all charges for services, drugs, special medical supplies, etc., before discounts or adjustments?

Total amount

\$ _____ .00

01 Don't know } SKIP to item 24
02 Not billed yet }

b. What dates are covered by the amount billed?

Month	Day	Year	to	Month	Day	Year

24. Which best describes the way this agency (will be/was) reimbursed for the total charges?

- 01 Based on services provided
- 02 Capitation (services provided under a capitation agreement or by salaried staff in an HMO)
- 03 Don't know

25. When was the last time service was provided to this patient?

Month	Day	Year

